Gardner Audiology **CHILD**

TODAY'S DATE: Please print clearly and complete all fields.

Patient Name (First / Middle Initial / Last / Suffix)	Sex	Date of Birth	Age	Social Sec Number

Preferred Name/Greeting:	Preferred contact person and relationship to patient:

Address (Street)	Preferred Language: English Spanish Other:

Address (City/State/Zip)	Cell Phone Number	Home Phone Number

E-mail Address	Preferred Method of Communication (Circle all that apply) Cell Phone Home Phone E-mail

Father's Name:	Father's address

Mother's Name:	Mother's address

Child's School:	Grade

Who recommended this hearing test: Doctor Friend/Family Member Parent Speech Therapist

Other (please list) _____

Primary Care Physician (first & last name)	Primary Care Physician's Phone Number & City

We will send all hearing evaluation results/reports to your Primary Care Physician. Please enter your initials to confirm _____

Person responsible for payment and relationship to patient	Address and Phone Number (if different from contact)

Insurance Information. We will request to scan your ID and insurance card(s).

Subscriber's Name (First/Middle/Last)	Subscriber's Date of Birth

Insurance Name	ID Number	Group Number	Relationship to Subscriber

Patient Authorizations

Insurance & Financial Authorizations:

I authorize the release of any information by Gardner Audiology to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Gardner Audiology. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Gardner Audiology's insurance policy. Refunds from services charged on a credit card will be returned to the same credit card.

Mail/Email Authorization: I authorize Gardner Audiology to contact me via mailing, phone, text, and email addresses given above. I understand my information will never be sold; however, I may receive future promotional materials from Gardner Audiology, including information from third party companies.

Treatment Authorization:

I hereby give Gardner Audiology consent for audiological treatment deemed advisable & necessary in the diagnosis and treatment of my hearing condition.

Medical Records Authorization:

I authorize the release of medical record information to 1) the above-named insurance companies 2) any physician who has participated in my health care, and 3) to any physician whom I may subsequently be referred.

I understand if I cancel or reschedule appointments with less than 24 hours' notice, I will be assessed a $50 cancelation fee.

Patient or Legal Guardian Signature:_____ Date:_____

PEDIATRIC CASE HISTORY Patient Name:_____

1. What is the primary reason for this appointment? _____
2. Do you feel your child's hearing is: stable fluctuates
3. Has he/she been diagnosed with any medical conditions or developmental disabilities? Yes No
   If yes, please list diagnoses: _____
4. Does your child have a history of ear infections? Yes No
   If yes, how many ear infections have they had? _____
5. Have tubes been placed in your child's ears or has your child had other ear surgeries? Yes No
   If yes, how many sets of tubes or type of ear surgery? _____
6. Did you have a normal pregnancy and delivery? Yes No
7. Was your child in neonatal intensive care for more than 5 days? Yes No
8. To your knowledge, did your child pass their newborn hearing screening? Yes No
9. Has anyone in your child's family been diagnosed with hearing loss before 30 years of age? Yes No
   If yes, who in the family has hearing loss and at what age?_____
10. Does your child complain of noises in his/her ears? (ringing, buzzing, roaring) Yes No
11. Does your child have a history of dizziness, imbalance, or falls? Yes No
12. Has your child's hearing been tested before by an audiologist? Yes No
    If yes, when was the last hearing test? _____Where? _____
    Results: _____
13. Does your child currently wear hearing aids? Yes No If yes, how old are the current aid(s)? _____

MEDICAL HISTORY:

Were any of the following present in your child's life? Please check all that apply

□ Anoxia (oxygen deprivation) □ Ototoxic medications (e.g. gentamycin, aminoglycoside, loop diuretics)

□ Infections at birth or in utero (e.g. CMV, herpes, rubella, syphilis, toxoplasmosis)

□ Postnatal infections associated with hearing loss (e.g. herpes, meningitis)

□ Syndromes associated with hearing loss (e.g. neurofibromatosis, Usher syndrome, Waardenburg syndrome, CHARGE, Down syndrome) □Measles □Meningitis □Mumps □ Allergies □ Hyperbilirubinemia (jaundice)

ACADEMIC DEVELOPMENT:

1. Is your child in school? Yes No Grade _____
2. How would you describe your child's academic performance/progress?_____
3. In what area is your child having difficulty? _____
4. Where is your child seated in the classroom? _____
5. Does your child currently receive support services (including speech language therapy, occupational therapy, physical therapy, special education)? Yes No If yes please explain type of services _____
   _____
6. Does your child seem to have any of the following issues? (Please check all that apply)
   □ Problems following directions □ Distracted by background noise □ Oral and written expression problems
   □ Remembering what they hear □ Difficulty with multi-step directions □ Learning to read

Acknowledgment of Receipt of Notice of Privacy Practices

Updated April 2021

I understand that, under the Health Insurance Portability & Accountability of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information ("PHI"). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been made aware that there is a copy of Gardner Audiology's privacy practices available upon request. This form contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact the office to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, marketing, or health care operations. I also understand you are not required to agree to my requested restrictions unless you are bound to abide by such restrictions.

- You can ask us to contact you in a specific way (for example, home, office, or cell phone, by text or email) or to send mail to a different address. We will say "yes" to all reasonable requests.

Acknowledgment of receipt of Notice of Privacy Practices regarding protected health information
I have received Gardner Audiology's Notice of Privacy. Photocopies of this document are to be as valid as the original.

Communication Preferences Regarding PHI (protected health information)
To assist in your hearing healthcare, it may be necessary to release your *Protected Health Information* to someone other than yourself. To whom may we communicate with? **Please include ANYONE who makes appointments for you or contacts the office on your behalf. Please clearly print in these fields.**

Primary Care Physician: _____

Other Physician(s): _____

Caregiver's Name(s): _____

Medical POA Name: _____

Other Person(s): _____

_____

_____

PATIENT: Print Name

_____ _____

PATIENT or Legal Guardian **Signature** Date